Senate

General Assembly

File No. 259

January Session, 2001

Substitute Senate Bill No. 1247

Senate, April 12, 2001

The Committee on Insurance and Real Estate reported through SEN. BOZEK of the 6th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING THE CONNECTICUT LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-860 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Sections 38a-858 to 38a-875, inclusive, as amended by this act, shall provide coverage for the policies and contracts specified in subsection **[**(b)**]** (f) of this section: **[**(1) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees of the persons covered under subdivision (2), and (2) to persons who are owners of or certificate holders under such policies or contracts or, in the case of unallocated annuity contracts, to the persons who are the contract holders, and who (A) are residents, or (B) are not residents, but only under all of the following conditions: (i) The insurers which issued such policies or contracts domiciled in this state; (ii) such

insurers never held a license or certificate or authority in the states in which such persons reside; (iii) such states have associations similar to the association created by this section and sections 38a-837, 38a-838, 38a-845, 38a-853, 38a-862, 38a-863, 38a-865 and 38a-866 and (iv) such persons are not eligible for coverage by such associations.] (1) To any person, except for a nonresident certificate holder under a group policy or contract, who is the beneficiary, assignee or payee of the person covered under subdivision (2) of this subsection, regardless of where the person resides, and (2) any person who is the owner of, or certificate holder under, such policy or contract and in each case who (A) is a resident, or (B) is not a resident, provided (i) the insurer that issued such policy or contract is domiciled in this state, (ii) the state in which the person resides has an association similar to the association created by this section and sections 38a-837, 38a-838, 38a-845, 38a-853, 38a-862, as amended by this act, 38a-863, as amended by this act, 38a-865, as amended by this act, and 38a-866, as amended by this act, and (iii) the person is not eligible for coverage by an association in any other state because the insurer was not licensed in the state at the time specified in the state's guaranty association law.

(b) For unallocated annuity contracts specified in subsection (f) of this section, subdivisions (1) and (2) of subsection (a) of this section shall not apply, and except as provided in subsections (d) and (e) of this section, sections 38a-858 to 38a-875, inclusive, as amended by this act, shall apply to: (1) Any person who is the owner of the unallocated annuity contract if the contract is issued to, or in connection with, a specific benefit plan whose plan sponsor has its principal place of business in this state; and (2) any person who is the owner of an unallocated annuity contract issued to, or in connection with, government lotteries if the owners are residents.

(c) For structured settlement annuities specified in subsection (f) of this section, subdivisions (1) and (2) of subsection (a) of this section shall not apply, and except as provided in subsections (d) and (e) of

this section, sections 38a-858 to 38a-875, inclusive, as amended by this act, shall apply to a person who is a payee under a structured settlement annuity, or to a beneficiary of a payee if the payee is deceased, if the payee: (1) Is a resident, regardless of where the contract owner resides, or (2) is not a resident, provided: (A) (i) The contract owner of the structured settlement annuity is a resident, or (ii) the contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by sections 38a-858 to 38a-875, inclusive, as amended by this act; and (B) neither the payee, beneficiary or contract owner is eligible for coverage by the association of the state in which the payee, beneficiary or contract owner resides.

(d) Sections 38a-858 to 38a-875, inclusive, as amended by this act, shall not provide coverage to: (1) A person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; or (2) a person covered under subsection (b) of this section, if any coverage is provided by the association of another state to the person.

(e) Sections 38a-858 to 38a-875, inclusive, as amended by this act, shall provide coverage to a person who is a resident and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under sections 38a-858 to 38a-875, inclusive, as amended by this act, is provided coverage under the laws of any other state, the person shall not be provided coverage under sections 38a-858 to 38a-875, inclusive, as amended by this act. In determining the application of the provisions of this subsection in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary or assignee, sections 38a-858 to 38a-875, inclusive, as amended by this act, shall be construed in conjunction with the laws of

other states to result in coverage by only one association.

[(b)] (f) (1) Sections 38a-858 to 38a-875, inclusive, as amended by this act, shall provide coverage to the persons specified in [subsection (a)] subsections (a) to (d), inclusive, of this section for direct, nongroup life, health [,] or annuity policies or contracts and supplemental [policies or] contracts to such policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by said sections. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement [agreements, lottery contracts] annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts. (2) Said sections 38a-858 to 38a-875, inclusive, as amended by this act, shall not provide coverage for: (A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder; (B) any policy or contract of reinsurance, unless assumption certificates have been issued; (C) any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value (i) averaged over the period of four years prior to the date on which the [association becomes obligated with respect to such policy or contract] member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, as amended by this act, exceeds [a] the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the [association became obligated] member insurer becomes an impaired or insolvent insurer under

sections 38a-858 to 38a-875, inclusive, as amended by this act, whichever is earlier; and (ii) on and after the date on which the [association becomes obligated with respect to such policy or contract] member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, as amended by this act, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available; (D) any plan or program of an employer, association or similar entity to provide life, health or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or similar entity under (i) a multiple employer welfare arrangement as defined in Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended from time to time; (ii) a minimum premium group insurance plan; (iii) a stop-loss group insurance plan; or (iv) an administrative services only contract; (E) any portion of a policy or contract to the extent that it provides dividends, [or] experience rating credits, voting rights or provides that any fees or allowances be paid to any person, including, but not limited to, the policy or contract holder, in connection with the service to or administration of such policy or contract; (F) any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state; (G) any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan; (H) any portion of [any] an unallocated annuity contract [which] that is not issued to, or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery; (I) any subscriber contract issued by a health care center; [and] (J) a contractual agreement that establishes the insurer's

obligation by reference to a portfolio of assets that is not owned or possessed by the insurance company; (K) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including, but not limited to: (i) A claim based on marketing materials; (ii) a claim based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements; (iii) a misrepresentation of or regarding policy benefits; (iv) an extra-contractual claim; or (v) a claim for penalties or consequential or incidental damages; (L) a contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer; and (M) a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, as amended by this act, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture.

[(c)**]** (g) The benefits for which the association may become liable shall in no event exceed the lesser of: (1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired insurer, or (2) (A) with respect to any one life, regardless

of the number of policies or contracts: (i) Three hundred thousand dollars in life insurance death benefits, but no more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance; (ii) five hundred thousand dollars in health insurance benefits, including, but not limited to, any net cash surrender and net cash withdrawal values; (iii) one hundred thousand dollars in the present value of annuity benefits, including, but not limited to, net cash surrender and net cash withdrawal values; (B) with respect to each individual participating in a governmental retirement plan established under Section [401(k)] 401, 403(b) or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, one hundred thousand dollars in present value annuity benefits, including, but not limited to, net cash surrender and net cash withdrawal values; (C) with respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, one hundred thousand dollars in present value annuity benefits, in the aggregate, including, but not limited to, net cash surrender and net cash withdrawal values, if any, provided [, however, that] (i) in no event shall the association be liable to expend more than the five hundred thousand dollars in the aggregate with respect to any one individual under subparagraphs (A), [and] (B) and (C) of this [subsection] subdivision except with respect to health insurance benefits under subparagraph (A) of this subdivision, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual, and (ii) with respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner; [. (C) With respect to any one contract holder covered by any unallocated annuity contract not included in subparagraph (B) of this subsection,

five million dollars in benefits, irrespective of the number of such contracts held by that contract holder**]** (D) with respect to either (i) one contract owner provided coverage under subparagraph (B) of subdivision (2) of subsection (b) of this section, or (ii) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subdivision (2) of subsection (f) of this section, five million dollars in benefits regardless of the number of contracts with respect to the contract owner or plan sponsor, except that in the case where one or more unallocated annuity contracts are covered contracts under sections 38a-858 to 38a-875, inclusive, as amended by this act, and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than five million dollars in benefits with respect to all such unallocated contracts.

(h) The limits set forth in subsection (g) of this section are limits on the benefits for which the association is obligated before taking into account either the association's subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer that are attributable to covered policies. The costs of the association’s obligations under sections 38a-858 to 38a-875, inclusive, as amended by this act, may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to the association's subrogation and assignment rights.

(i) In performing its obligation to provide coverage under section 38a-865, as amended by this act, the association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that

does not materially affect the economic value or economic benefit of the covered policy or contract.

Sec. 2. Section 38a-862 of the general statutes is repealed and the following is substituted in lieu thereof:

As used in sections 38a-858 to 38a-875, inclusive, as amended by this act:

[(a)**]** (1) "Account" means either of the two accounts created under section 38a-863, as amended by this act;

[(b)**]** (2) "Association" means the Connecticut Life and Health Insurance Guaranty Association created under **[**said**]** section 38a-863, as amended by this act;

(3) "Authorized assessment" or "authorized" when used in the context of assessments means a resolution that has been passed by the board of directors of the association whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(4) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(5) "Called assessment" or "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth in the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

[(c)**]** (6) "Commissioner" means the Insurance Commissioner of this state;

[(d)**]** (7) "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section 38a-860, as amended by this act;

[(e)**]** (8) "Covered policy" means any policy or contract within the scope of section 38a-860, as amended by this act;

(9) "Entity" means a person other than a natural person;

[(f) "Impaired insurer" means: (1) A licensed insurer which, after October 1, 1972, becomes insolvent and is placed under a final order of liquidation, rehabilitation, or conservation by a court of competent jurisdiction, or (2) an insurer deemed by the commissioner after October 1, 1972, to be unable or potentially unable to fulfill its contractual obligations;**]**

(10) "Impaired insurer" means a member insurer that, after October 1, 1972, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(11) "Insolvent insurer" means a member insurer that after October 1, 1972, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

[(g)**]** (12) "Member insurer" means any insurer licensed or who holds a certificate of authority to issue in this state any kind of insurance to which sections 38a-858 to 38a-875, inclusive, as amended by this act, apply under section 38a-860, as amended by this act, and may include an insurer whose license in this state has been suspended, revoked or voluntarily withdrawn. "Member insurer" **[**shall**]** does not include a health care center;

[(h)**]** (13) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's Investors

Service, Inc., or any successor thereto;

(14) "Owner", "policy owner" or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. "Owner", "contract owner" and "policy owner" does not include a person with a mere beneficial interest in a policy or contract;

(15) "Plan sponsor" means: (A) The employer in the case of a benefit plan established or maintained by a single employer; (B) the employee organization in the case of a benefit plan established or maintained by an employee organization; or (C) in the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan;

[(i)**]** (16) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. "Premiums" does not include (A) any amounts or considerations received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection **[**(b)**]** (f) of section 38a-860, as amended by this act, except that assessable premium shall not be reduced on account of subparagraph (C) of subdivision (2) of subsection **[**(b)**]** (f) of section 38a-860, as amended by this act, relating to interest limitations, and subdivision (2) of subsection **[**(c)**]** (g) of section 38a-860, as amended by this act, relating to limitations with respect to any one individual, any one participant and any one contract **[**holder**]** owner;

provided that "premiums" shall not include any premiums in excess of five million dollars on any unallocated annuity contract not issued under a governmental retirement benefit plan established under Section [401(k)] 401, 403(b) or 457 of the [United States Internal Revenue Code] Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, or (B) with respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars with respect to such policies or contracts, regardless of the number of policies or contracts held by the owner;

[(j)] (17) "Person" means any individual, corporation, limited liability company, partnership, association or voluntary organization;

(18) "Principal place of business" of a plan sponsor or an entity means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the plan sponsor or entity as a whole primarily exercises that function, as determined by the association in its reasonable judgment by considering the factors set forth in subparagraphs (A) to (G), inclusive, of this subdivision: (A) The state in which the primary executive and administrative headquarters of the plan sponsor or entity is located; (B) the state in which the principal office of the chief executive officer of the plan sponsor or entity is located; (C) the state in which the board of directors, or similar governing person or persons, of the plan sponsor or entity conducts the majority of its meetings; (D) the state in which the executive or management committee of the board of directors, or similar governing person or persons, of the plan sponsor or entity conducts the majority of its meetings; (E) the state from which the management of the overall operations of the plan sponsor or entity is directed; (F) in the case of a benefit plan sponsored by affiliated

companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors set forth in subparagraphs (A) to (E), inclusive, of this subdivision; and (G) notwithstanding subparagraphs (A) to (F), inclusive, of this subdivision, in the case of a plan sponsor, if more than fifty per cent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in subparagraph (C) of subdivision (15) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question;

(19) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer;

[(k)**]** (20) "Resident" means **[**any person who resides in this state at the time a member insurer is determined to be an impaired insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business**]** a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one state, which in the case of an entity shall be its principal place of business. Citizens of the United States that are either (A) residents of foreign countries, or (B) residents of United States

possessions, territories or protectorates that do not have an association similar to the association created by sections 38a-858 to 38a-875, inclusive, as amended by this act, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts;

(21) "Structured settlement annuity" means an annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;

[(l)**]** (22) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds under a life, health or annuity policy or contract; and

[(m)**]** (23) "Unallocated annuity contract" means any annuity contract or group annuity certificate **[**which**]** that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

Sec. 3. Section 38a-863 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) There is created a nonprofit legal entity to be known as the Connecticut Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section 38a-867 and shall exercise its powers through a board of directors established under section 38a-864. For purposes of administration and assessment, the association shall maintain two accounts: (1) The life insurance and annuity account which includes the following subaccounts: (A) Life insurance account; (B) annuity account which shall include, but is not limited to, annuity contracts owned by a governmental retirement plan, or its trustee,

established under Section 401, 403(b) or 457 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, but shall otherwise exclude unallocated annuities; and (C) unallocated annuity account which shall **[**include contracts qualified under Section 403(b) of the United States Internal Revenue Code**]** exclude contracts owned by a governmental retirement benefit plan, or its trustee, established under Section 401, 403(b) or 457 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended; and (2) the health insurance account.

(b) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

Sec. 4. Section 38a-865 of the general statutes is repealed and the following is substituted in lieu thereof:

[In addition to the powers and duties enumerated in sections 38a-858 to 38a-875, inclusive:

(a) If a domestic insurer is an impaired insurer, the association may, prior to an order of liquidation or rehabilitation, and subject to any conditions imposed by the association other than those which impair the contractual obligations of the impaired insurer, and approved by the impaired insurer and the commissioner: (1) Guarantee or reinsure, or cause to be guaranteed, assumed or reinsured, all the covered policies of the impaired insurer; (2) provide such moneys, pledges, notes, guarantees or other means as are proper to effectuate subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this subsection; (3) loan money to the impaired insurer.

(b) If a foreign or alien insurer is an impaired insurer, the

association may, prior to an order of liquidation, rehabilitation, or conservation, with respect to the covered policies of residents and subject to any conditions imposed by the association other than those which impair the contractual obligations of the impaired insurer, and approved by the impaired insurer and the commissioner: (1) Guarantee or reinsure, or cause to be guaranteed, assumed or reinsured, the impaired insurer's covered policies of residents; (2) provide such moneys, pledges, notes, guarantees or other means as are proper to effectuate subdivision (1) of this subsection, and assure payment of the impaired insurer's contractual obligations to residents pending action under subdivision (1) of this subsection; (3) loan money to the impaired insurer.

(c) If a domestic insurer is an impaired insurer under an order of liquidation or rehabilitation, the association shall, subject to the approval of the commissioner: (1) Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured the covered policies of the impaired insurer; (2) assure payment of the contractual obligations of the impaired insurer; and (3) provide such moneys, pledges, notes, guarantees or other means as are reasonably necessary to discharge such duties. If the association fails to act within a reasonable period of time, the commissioner shall have the powers and duties of the association under sections 38a-858 to 38a-875, inclusive, with respect to such domestic impaired insurer.

(d) If a foreign or alien insurer is an impaired insurer under an order of liquidation, rehabilitation or conservation, the association shall, subject to the approval of the commissioner, (1) guarantee, assume or reinsure or cause to be guaranteed, assumed or reinsured the covered policies of residents; (2) assure payment of the contractual obligations of the impaired insurer to residents; and (3) provide such moneys, pledges, notes, guarantees or other means as are reasonably necessary to discharge such duties. If the association fails to act within a reasonable period of time, the commissioner shall have the powers

and duties of the association under sections 38a-858 to 38a-875, inclusive, with respect to such foreign or alien impaired insurer.

(e) (1) In carrying out its duties under subsections (c) and (d), the association may request that there be imposed policy liens, contract liens, moratoriums on payments or other similar means and such liens, moratoriums or similar means may be imposed if the commissioner finds that the amounts which can be assessed under sections 38a-858 to 38a-875, inclusive, are less than the amounts needed to assure full and prompt performance of the impaired insurer's contractual obligations, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens, moratoriums, or similar means to be in the public interest, and approves the specific policy liens, contract liens, moratoriums or similar means to be used. (2) Before being obligated under subsections (c) and (d) the association may request that there be imposed temporary moratoriums or liens on projects of cash values and policy loans and such temporary moratoriums and liens may be imposed if they are approved by the commissioner.**]**

(a) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner, (1) guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, any or all of the policies or contracts of the impaired insurer; or (2) provide such moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this subsection.

(b) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(1) (A) (i) Guarantee, assume or reinsure, or cause to be guaranteed,

assumed or reinsured, the policies or contracts of the insolvent insurer, or (ii) assure payment of the contractual obligations of the insolvent insurer, and (B) provide moneys, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the association's duties; or

(2) Provide benefits and coverages in accordance with the following provisions:

(A) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred: (i) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five days, but in no event less than thirty days after the date on which the association becomes obligated with respect to the policies and contracts; (ii) with respect to nongroup policies, contracts and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than thirty days from the date on which the association becomes obligated with respect to the policies or contracts;

(B) Make diligent efforts to provide all known insureds or annuitants, for nongroup policies and contracts, or group policy owners with respect to group policies and contracts, thirty days notice of the termination of benefits pursuant to subparagraph (A) of this subdivision;

(C) With respect to nongroup life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual

basis in accordance with the provisions of subparagraph (D) of this subdivision, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time during which the insurer had no right to make unilateral changes in any provision of the policy or annuity or had a right only to make changes in premium by class;

(D) In providing the substitute coverage required under subparagraph (C) of this subdivision, the association may offer either to reissue the terminated coverage or to issue an alternative policy. Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy. The association may reinsure any alternative or reissued policy;

(E) Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance commissioner and the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency;

(F) Alternative policies adopted by the association shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten;

(G) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer as determined by the association;

(H) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance commissioner and the receivership court;

(I) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the owner, the insured or the association;

(J) When proceeding under this subdivision with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subparagraph (C) of subdivision (2) of subsection (f) of section 38a-860, as amended by this act.

(c) Nonpayment of premiums by the thirty-first day after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under sections 38a-858 to 38a-875, inclusive, as amended by this act, with respect to the policy or coverage, except with respect to any claims incurred or any net surrender value that may be due in accordance with the provisions of sections 38a-858 to 38a-875, inclusive, as amended by this act.

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(e) The protection provided by sections 38a-858 to 38a-875, inclusive, as amended by this act, shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(f) Repealed by P.A. 87-290, S. 7, 8.

[(g) The association may render assistance and advice to the commissioner, upon his request, concerning rehabilitation, payment of claims, continuations of coverage or the performance of other contractual obligations of any impaired insurer.

(h) The association shall have standing to appear before any court in this state with jurisdiction over an impaired insurer concerning which the association is or may become obligated under sections 38a-858 to 38a-875, inclusive. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring or guaranteeing the covered policies of the impaired insurer and the determination of the covered policies and contractual obligations.

(i) (1) Any person receiving benefits under sections 38a-858 to 38a-875, inclusive, shall be deemed to have assigned his rights under the covered policy to the association to the extent of the benefits received because of said sections, whether the benefits are payments of contractual obligations or continuation of coverage. The association may require an assignment to it of such rights by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by said sections upon such person. The association shall be subrogated to these rights against the assets of any impaired insurer. (2) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired insurer as that possessed by the person entitled to receive benefits under said sections.

(j) The association may (1) enter into such contracts as are necessary or proper to carry out the provisions and purposes of sections 38a-858 to 38a-875, inclusive; (2) sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under section 38a-866; (3) borrow money to effect the purposes of sections 38a-858 to 38a-875, inclusive. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets; (4) employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under said sections; (5) negotiate and contract with any liquidator, rehabilitator, conservator or ancillary receiver to carry out the powers and duties of the association; (6) take such legal action as may be necessary to avoid payment of improper claims; (7) exercise, for the purposes of said sections and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform the contractual obligations of the impaired insurer.

(k) When proceeding under subsection (c) or (d) of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting rate of interest consistent with subparagraph (C) of subdivision (2) of subsection (b) of section 38a-860.

(l) The protection provided by sections 38a-858 to 38a-875, inclusive, shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired insurer other than this state.**]**

(g) In carrying out its duties under subsection (b) of this section, the association may:

(1) Subject to approval by a court in this state, impose permanent

policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under sections 38a-858 to 38a-875, inclusive, as amended by this act, are less than the amounts needed to assure full and prompt performance of the association's duties under sections 38a-858 to 38a-875, inclusive, as amended by this act, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest;

(2) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(h) If the association fails to act within a reasonable period of time with respect to any insolvent insurer, as provided in subsection (b) of this section, the commissioner shall have the powers and duties of the association under sections 38a-858 to 38a-875, inclusive, as amended by this act, with respect to the insolvent insurer.

(i) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning

rehabilitation, payment of claims, continuation of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

(j) The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under sections 38a-858 to 38a-875, inclusive, as amended by this act, or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(k) (1) A person receiving benefits under sections 38a-858 to 38a-875, inclusive, as amended by this act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages, shall be deemed to have assigned (A) the rights under the covered policy or contract to the association to the extent of the benefits received under sections 38a-858 to 38a-875, inclusive, as amended by this act, and (B) any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of sections 38a-858 to 38a-875, inclusive, as amended by this act. The association may require an assignment to it of such rights or cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits under sections 38a-858

to 38a-875, inclusive, as amended by this act, upon the person.

(2) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under sections 38a-858 to 38a-875, inclusive, as amended by this act.

(3) In addition to subdivisions (1) and (2) of this subsection, the association shall have, originally or by succession, all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to the policy or contracts, against a person responsible for the losses arising from the personal injury relating to the annuity or payment thereof, except any such person responsible solely by reason of serving as an assignee with respect to a qualified assignment under Section 130 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended. Such rights of the association shall include, but are not limited to, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to sections 38a-858 to 38a-875, inclusive, as amended by this act.

(4) If the provisions of subdivisions (1) to (3), inclusive, of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association

has rights as described in subdivisions (1) to (4), inclusive, of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(l) In addition to the rights and powers elsewhere in sections 38a-858 to 38a-875, inclusive, as amended by this act, the association may:

(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of sections 38a-858 to 38a-875, inclusive, as amended by this act;

(2) Sue or be sued, including, but not limited to, taking any legal actions necessary or proper to recover any unpaid assessments under section 38a-866, as amended by this act, and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of sections 38a-858 to 38a-875, inclusive, as amended by this act, and any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary or proper to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under sections 38a-858 to 38a-875, inclusive, as amended by this act;

(5) Take such legal action as may be necessary or proper to avoid or recover payment of improper claims;

(6) Exercise, for the purposes of sections 38a-858 to 38a-875, inclusive, as amended by this act, and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under sections 38a-

858 to 38a-875, inclusive, as amended by this act;

(7) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under sections 38a-858 to 38a-875, inclusive, as amended by this act, with respect to the person, and the person shall promptly comply with the request; and

(8) Take other necessary or proper action to discharge its duties and obligations under sections 38a-858 to 38a-875, inclusive, as amended by this act, or to exercise its powers under sections 38a-858 to 38a-875, inclusive, as amended by this act.

(m) The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

(n) (1) At any time within one year after the date on which the association becomes responsible for the obligations of a member insurer, which date shall be deemed the coverage date, the association may elect to succeed to the rights and obligations of the member insurer that accrue on or after the coverage date and that relate to contracts covered, in whole or in part, by the association, under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association, except that the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator or liquidator of a member insurer has previously and expressly disaffirmed the reinsurance agreement. The election shall be effected by a notice to the receiver, rehabilitator or liquidator and to the affected reinsurers. If the association makes an election, then subparagraphs (A) to (D), inclusive, of this subdivision shall apply with respect to the agreements selected by the association: (A) The association shall be responsible for all unpaid premiums due under the agreements for periods before, on and after the coverage date, and shall be responsible

for the performance of all other obligations to be performed after the coverage date, in each case which relate to contracts covered in whole or in part by the association. The association may charge contracts covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association. (B) The association shall be entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the association in whole or in part, and upon the association's receipt of any such amount, the association shall pay any beneficiary of a policy or contract under which the association paid only a portion of the policy or contract amount: (i) The amount received by the association that exceeds the benefits paid the beneficiary under the policy, less (ii) the benefits paid by the association on account of the policy or contract less the retention of the impaired or insolvent member insurer applicable to the loss or event. (C) Not later than thirty days after the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by either the member insurer or its receiver, rehabilitator or liquidator or the indemnity reinsurer during the period between the coverage date and the date of the association's election. Either the association or indemnity reinsurer shall pay the net balance due the other not later than five days after the completion of the calculation. If the receiver, rehabilitator or liquidator has received any amounts due the association pursuant to subparagraph (B) of this subdivision, the receiver, rehabilitator or liquidator shall remit the same to the association as promptly as practicable. (D) If the association, not later than sixty days after the election, pays the premiums due for periods before, on and after the coverage date that relate to contracts covered by the association in whole or in part, the reinsurer shall not be entitled to terminate the reinsurance agreements

insofar as the agreements relate to contracts covered by the association in whole or in part and shall not be entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the association.

(2) If the association transfers its obligations to another insurer, and if the association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the association under subdivision (1) of this subsection, provided: (A) The indemnity reinsurance agreements shall automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary; and (B) the association's obligation to pay the beneficiary pursuant to subparagraph (B) of subdivision (1) of this subsection shall no longer apply on or after the date the indemnity reinsurance agreement is transferred to the third party insurer. This subdivision shall not apply if the association has previously expressly determined in writing that it will not exercise the election referred to in subdivision (1) of this subsection.

(3) The provisions of this subsection shall supercede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds on account of losses or events that occur in periods after the coverage date to the receiver, liquidator or rehabilitator of the insolvent member insurer. The receiver, rehabilitator or liquidator shall remain entitled to any amount payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods prior to the coverage date subject to applicable setoff provisions.

(4) Except as otherwise expressly provided in this subsection, nothing in this section shall alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. Nothing in this section shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement.

Nothing in this section shall give a policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

(o) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of sections 38a-858 to 38a-875, inclusive, as amended by this act, in an economical and efficient manner.

(p) Where the association has arranged or offered to provide the benefits of sections 38a-858 to 38a-875, inclusive, as amended by this act, to a covered person under a plan or arrangement that fulfills the association's obligations under sections 38a-858 to 38a-875, inclusive, as amended by this act, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(q) Venue in a suit against the association arising under sections 38a-858 to 38a-875, inclusive, as amended by this act, shall be in the superior court for the judicial district of Hartford. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under sections 38a-858 to 38a-875, inclusive, as amended by this act.

(r) In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under subsections (a) or (b) of this section, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with subdivisions (1) to (3), inclusive, of this subsection: (1) In lieu of the index or other external reference provided for in the original policy or

contract, the alternative policy or contract provides for (A) a fixed interest rate, (B) payment of dividends with minimum guarantees, or (C) a different method for calculating interest or changes in value; (2) there is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and (3) the alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Sec. 5. Section 38a-866 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such times and for such amounts as the board finds necessary. **[**The board shall collect the assessments after thirty days' written notice to the member insurers before payment is due.**]** The association shall establish a due date for each assessment which shall be at least thirty days after the association has provided the member notice of the assessment. Each member insurer shall pay interest on any late payment at the rate of one per cent per month, or any portion thereof, from the due date to the date of payment.

(b) There shall be **[**three**]** two classes of assessments, as follows: (1) Class A assessments shall be made for the purpose of meeting administrative costs and other general expenses not related to a particular impaired or insolvent insurer; (2) Class B assessments shall be **[**made**]** authorized and called to the extent necessary to carry out the powers and duties of the association under section 38a-865, as amended by this act, with regard to an impaired **[**domestic**]** or insolvent insurer. **[**; (3) Class C assessments shall be made to the extent necessary to carry out the powers and duties of the association under said section 38a-865, with regard to an impaired foreign or alien insurer.**]**

(c) (1) The amount of any Class A assessment [for each account] shall be determined by the board and may be [made] authorized and called on a pro-rata or non-pro-rata basis. If an assessment is made on a pro-rata basis, the board may provide that the assessment be credited against future Class B assessments. The total of all non-pro-rata assessments shall not exceed one hundred fifty dollars per member insurer in any calendar year. The amount of any Class B [or C] assessment shall be [divided among the accounts in the proportion that the premiums received by the impaired insurer on the policies covered by each account bears to the premiums received by such insurer on all covered policies;] allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard that the board, in its sole discretion, deems as being fair and reasonable under the circumstances.

(2) Class [C] B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account [bears] for the three most recent calendar years for which information is available preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the insurer became impaired bear to such premiums received on business in this state for those calendar years by all assessed member insurers. [; (3) Class B assessments for each account shall be made separately for each state in which the impaired domestic insurer was authorized to transact insurance at any time, in the proportion that the premiums received on business in such state by the impaired insurer on policies covered by such account bears to such premiums received in all such states by the impaired insurer. The assessments against member insurers shall be in the proportion that the premiums received

on business in each such state by each assessed member insurer on policies covered by each account bears to such premiums received on business in each state by all assessed member insurers; (4) assessments**]**

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be **[**made**]** authorized or called until necessary to implement the purposes of sections 38a-858 to 38a-875, inclusive, as amended by this act. Classification of assessments under subsection (b) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro-rata share of an authorized assessment that is not yet called not later than one hundred eighty days after the association authorizes the assessment.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(e) (1) (A) **[**The**]** Subject to the provisions of subparagraph (B) of this subdivision, the total of all assessments **[**upon**]** authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for **[**each subaccount thereunder**]** the health account shall not in any one calendar year

exceed two per cent [and for the health account shall not in any one calendar year exceed two per cent of] such insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. (B) If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage shall be equal and limited to the higher of the three-year average annual premium for the applicable subaccount or account as calculated pursuant to this section. (C) If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by sections 38a-858 to 38a-875, inclusive, as amended by this act.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If [a one per cent] the maximum assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subdivision (2) of subsection (c) of this section, the board shall access [all] the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subdivision (1) of this subsection.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the

assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that **[**amount**]** account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.

(g) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of sections 38a-858 to 38a-875, inclusive, as amended by this act, to consider the amount reasonably necessary to meet its assessment obligations under said sections.

(h) **[**(1)**]** Each insurer paying an assessment under sections 38a-858 to 38a-875, inclusive, as amended by this act, may offset one hundred per cent of the amount of such assessment against its premium tax liability to this state under chapter 207. Such offset shall be taken over a period of the five successive tax years following the year of payment of the assessment, at the rate of twenty per cent per year of the assessment paid to the association. Each insurer **[**which**]** that has offset assessments paid to the association against its premium tax liability to the state shall pay to the Department of Revenue Services one hundred per cent of any sums **[**which**]** that are acquired by refund from the association pursuant to subsection (f) of this section. The association shall promptly notify the commissioner of the name and address of the insurers to which such refunds have been made, the amount of such refunds, and the date on which such refunds were mailed to such insurer. If the amount that an insurer is required to pay to the Department of Revenue Services has not been so paid on or before the thirtieth day after the date of mailing of such refunds, the insurer shall be liable for interest on such amount at the rate of one per cent per month, or **[**fraction**]** portion thereof, from such thirtieth day to the date of payment.

[(2) An insurer may transfer any offset provided under this subsection to an affiliate, as defined in section 38a-1, of that insurer.**]**

(i) (1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a written statement that (A) the payment is made under protest, and (B) includes a brief statement of the grounds for the protest. (2) Not later than sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest. (3) Not later than thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of the final decision. (4) Not later than sixty days after receipt of notice of the final decision, the protesting member insurer may appeal the final action to the commissioner. (5) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with a recommendation from the association. (6) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association.

(j) The association may request information from member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with such request.

INS *JOINT FAVORABLE SUBST.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: None

Affected Agencies: None

Municipal Impact: None

Explanation

State Impact:

The bill revises the statutes governing the Connecticut Life and Health Insurance Guaranty Association Act. The changes identify who is covered, the types of policies and insurance contracts covered and the circumstances under which coverage is afforded in the event an insurer becomes financially impaired or insolvent. The bill updates the statutes to cover new life insurance products with investment features and broadens the association's authority. The bill has no fiscal impact on the Department of Insurance.

OLR Bill Analysis
sSB 1247

AN ACT CONCERNING THE CONNECTICUT LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT.

SUMMARY:
This bill revises the statutes governing the Connecticut Life and Health Insurance Guaranty Association ((CLHIGA) to identify (1) who is covered, (2) the types of policies and contracts covered, and (3) the circumstances under which coverage is afforded an insurer who becomes financially impaired or insolvent. It updates the statutes to (1) cover new life insurance products with investment features; (2) modifies coverage limitations, restrictions, and exclusions; (3) simplifies the provisions that trigger coverage; and (4) broadens the association's authority.

Specifically, the bill

1. changes the criteria used to determine which owners, payees, beneficiaries, and assignees of unallocated and structured settlement annuities are covered under the act and adds certain types of funding agreements and annuities to the list of products covered;

2. adds rules for determining who is covered in different states and which state's statute to use to determine the existence and limits of guaranty fund coverage;

3. sets rate of return coverage limits for certain life insurance products that have equity-index features;

4. excludes coverage for certain claims;

5. adds per life and aggregate monetary limits for certain annuity claimants, an aggregate per person limit for health insurance

benefits, and certain maximum limits on the CLHIGA's total financial obligation;

6. adds authority for the CLHIGA to provide certain benefits and coverage when an insurer is impaired or insolvent and specifies related conditions and limitations;

7. revises CLHIGA's authority to impose policy liens, acquire subrogation and assignment rights, and intervene in court and agency proceedings;

8. authorizes the CLHIGA to enter into certain reinsurance agreements in discharging its duties and gives its board of directors greater discretion in determining the means by which it provides benefits;

9. makes several changes in the process for determining CLHIGA assessments and establishes a procedure for member insurers to protest an assessment; and

10. adds new definitions and revises others.

Finally, the bill expands CLHIGA's coverage to include U.S. citizens residing in foreign countries or a U.S. possession, territory, or protectorate that does not have an association similar to the CLHIGA. It requires that they be deemed residents of the state of domicile of the insurer that issued the policy or contract.

EFFECTIVE DATE: October 1, 2001

COVERAGE, LIMITATIONS, AND EXCLUSIONS

Under current law, CLHIGA covers the financial obligations of resident owners and certificate holders of individual life and health insurance policies or annuity contracts, and supplements to them; the beneficiaries, assignees, or payees of resident owners and certificate holders; and nonresidents if (1) the issuing insurer is domiciled in the state, (2) the person resides in a state with an association similar to CLHIGA, or (3) the person is not eligible for association coverage in any state because the issuing insurer was unlicensed at the time

specified in the state's law. It also covers group certificates and annuity contracts issued by member insurers under life and health insurance policies and contracts.

Unallocated and Structured Settlement Annuities

The bill changes the criteria for CLHIGA coverage of unallocated and structured settlement annuities. CLHIGA covers the owner of an unallocated annuity contract, instead of the contract holder, if it is issued to, or in connection with, a benefit plan whose sponsor has his principal place of business in the state, rather than the state where the contract holder is located. An unallocated annuity is an annuity that is not issued to and owned by an individual, except to the extent of benefits guaranteed to an individual by an insurer.

It adds coverage for allocated funding agreements, and for unallocated annuities issued in connection with government lotteries if the owner is a resident.

It covers resident payees of structured settlement annuities and their beneficiaries, if the payee is deceased, and the payee (a) is a resident, or (b) is not a resident but the contract owner is a resident, the insurer that issued the contract is domiciled in the state, the state where the contract owner resides has an association similar to CLHIGA, and neither the payee, beneficiary, or owner is eligible for coverage by the association in the state where they live. Current law requires structured settlement coverage to be based on where the nominal owner resides. A structured settlement annuity is an annuity purchased to fund periodic payments to a plaintiff or other claimant for personal injuries.

Coverage in Another State

The bill prohibits CLHIGA coverage of both an unallocated or structured settlement annuity when the payee or beneficiary of a resident owner is afforded coverage by another state association.

If any coverage is provided by another state's association, the bill prohibits coverage to unallocated annuity owners when the benefit plan sponsor's principal place of business is the state or when the

annuity is issued to a resident owner in connection with a government lottery.

The bill specifies that to avoid duplicate coverage, if a person who would otherwise receive coverage, is covered under the laws of any other state, he may not be covered under the bill. In determining the application of this prohibition against duplicate coverage, the bill specifies that if more than one state's association could cover someone, whether as an owner, payee, beneficiary, or assignee, the bill must be construed in conjunction with other state laws to result in coverage by only one association.

Life Insurance Limitation

The bill excludes CLHIGA coverage for excess rate of return or interest determined by an index or other external reference in a life insurance policy. CLHIGA does not cover the rate or change in value that exceeds (1) the amount of the average return over the four years before the date of the impairment or insolvency determined by subtracting two percentage points from Moody's corporate bond yield average for (a) the same period or (b) a lesser period if the policy was issued less than four years before the impairment or insolvency, whichever is earlier; and (2) on or after the date of the impairment or insolvency, the rate of return determined by subtracting three percentage points from the most recent Moody's corporate bond yield average.

Exclusion of Certain Claims

The bill excludes the following claims from CLHIGA coverage:

1. claims not based on the written terms of the policy or contract;

2. claims based on marketing material, side letters, riders or other documents that do not meet policy form filing or approval requirements;

3. claims based on misrepresentation of policy benefits; and

4. extra-contractual claims and claims for penalties or consequential or incidental damages.

The bill excludes coverage for contractual agreements (certain guaranteed investment contracts) that establish a member insurer's obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets owned by the benefit plan or its trustee, which is not affiliated with the insurer. It excludes claims for interest or changes in value that are determined by an index or external reference that have not been credited to the policy or have been forfeited on the date the insurer becomes impaired or insolvent, whichever is earlier. If interest or changes in value are credited less than annually, the values not forfeited must be set as specified under the policy and credited as of the date of impairment or insolvency, whichever is earlier. The bill also specifies that claims under unallocated annuity contracts protected by the federal Pension Benefit Guaranty Corporation are excluded whether or not the corporation has become liable to make payment.

Monetary Limitations

The bill adds the following monetary limits for annuities, and health and life insurance:

1. $100,000 limit in present value annuity benefits, including net cash surrender and withdrawal values, on the obligation of CLHIGA to each payee or his beneficiary of a structured settlement annuity, and a $500,000 aggregate limit to any one individual;

2. $500,000 aggregate health insurance limit for any one individual;

3. $5 million for one owner of multiple individual life insurance policies, whether an individual, firm, corporation or other person, and whether the insureds are officers, managers, employees, or other persons;

4. $5 million with respect to one owner under a government retirement plan or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts, regardless of the number of contracts or plan sponsors. If any unallocated annuity contract is covered by CLHIGA and is owned by a trust or other entity for the benefit of two or more plan sponsors, CLHIGA covers

the largest interest in the trust or entity owning the contract up to $5 million if the plan sponsor's principal place of business is in the state.

The bill specifies that (1) CLHIGA's monetary obligations are subject to its subrogation (the right of an insurer to recover from a third party the amount paid under a policy) and assignment (the transfer of the legal right or interest in a policy to another party) rights or its ability to pay for benefits out of the assets of the impaired or insolvent insurer and (2) CLHIGA's costs may be met through the use of assets attributable to covered policies or reimbursed through subrogation or assignment rights.

Finally, the bill specifies that CLHIGA's obligation to provide coverage must not require it to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed the impaired or insolvent insurer's contractual obligations under covered policies or contracts that do not materially affect the economic value or benefit of the policies or contracts.

PROVIDING BENEFITS AND COVERAGE

If CLHIGA does not guarantee, assume, or reinsure an insolvent insurer's policies or contracts, the bill requires it to provide benefits and coverage as follows:

1. in the case of group life and health insurance policies and annuity contracts, assure payment of benefits for premiums identical to the premiums and benefits, except for conversion and renewal terms, that would have been paid under the insolvent insurer's policies and contracts for incurred claims no later than the earlier of the policy or contract's next renewal date or 45 days, but not less than 30 days after the date CLHIGA becomes obligated;

2. in the case of individual life and health insurance policies and annuity contracts, assure payment of benefits for premiums identical to those that would have been paid under the insolvent insurer's policies and contracts for incurred claims no later than the earlier of the policy or contract's renewal date or one year, but not less than 30 days after the date CLHIGA becomes obligated;

3. make diligent efforts to provide 30 days notice of the termination of benefits to all known individual and group policy or contract owners, insureds, or annuitants;

4. make available substitute coverage on an individual basis under a group policy to annuitants, insureds or owners of covered individual life and health insurance policies or annuity contracts and former insureds or annuitants who are not eligible for replacement group coverage, if they had a right under law or the terminated policy or contract to (a) convert to individual coverage, (b) continue an individual policy or contract until a specified age or time during which the insurer had no right to make provision changes or had a right to make only class premium changes;

5. provide substitute coverage by offering to either reissue the terminated coverage or issue an alternative policy without requiring evidence of insurability, a waiting period, or exclusions that would not have applied under the terminated policy. (CLHIGA may reinsure any alternative or reissued policy).

Alternative Policies

CLHIGA may adopt various types of alternative policies for future use without regard to any particular impairment or insolvency but must get the domiciliary insurance commissioner and the receivership court's approval for policies adopted for a specific impairment or insolvency. Alternative policies must contain the minimum statutory provisions required in Connecticut and provide reasonable benefits in relation to the premium charged. CLHIGA must set premiums in accordance with a table it adopts, and premiums must reflect the amount of insurance provided, and the age and risk class of each insured, but not changes in the insured's health after the original policy was last underwritten. Alternative policies must provide coverage similar to that provided by the impaired or insolvent insurer.

Reissued Coverage

If CLHIGA elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, it must set the

premium in accordance with the amount of insurance provided, the insured's age and risk class and subject to the domiciliary insurance commissioner and the receivership court's approval.

CLHIGA's coverage obligation under any impaired or insolvent insurer's policy or contract or any reissued or alternative policy or contract ceases when the owner, insured, or CLHIGA replaces it with another policy or contract.

For policies or contracts with guaranteed minimum interest rates, CLHIGA must assure payment or crediting of interest consistent with the limitation on interest rate payments.

The bill specifies that CLHIGA's obligation under any guaranteed, assumed, alternative, or reissued policy or contract terminates if premiums are not paid by the 31st day after the date required under the policy or contract, except for claims already incurred or net surrender values that may be due. Premiums due for coverage after entry of an order of insolvency belong and must be paid to CLHIGA, and CLHIGA is liable for any unearned premiums due the policy or contract owner.

The bill authorizes CLHIGA, subject to the receivership court's approval, to issue substitute coverage under an alternative policy or contract for one that provides an interest rate or crediting rate determined by the use of an index or other external reference to calculate returns or changes in value. The alternative policy provides (1) a fixed interest rate, in lieu of the index or external reference under the original policy; (2) payment of dividends with minimum guarantees; or (3) a different method of calculating interest or changes in value. No evidence of insurability, waiting period, or other exclusion that would not have applied to the replaced policy can apply to the alternative policy, and it must be substantially similar to the replaced policy in all other material terms.

Finally, the bill specifies that its protections do not apply where guaranty protection under the laws of the impaired or insolvent insurer's domiciliary state or jurisdiction is provided to any Connecticut resident. It also specifies that where CLHIGA arranges or provides benefits to a covered person under a plan or arrangement

that fulfills it's obligation, the person is not entitled to benefits from another association in addition to or other than those provided under the plan or arrangement.

LIENS, MORATORIUMS, INTERVENTION, ASSIGNMENT OF RIGHTS, AND SUBROGATION

Liens and Moratoriums

The bill requires a Connecticut court's approval, rather than the insurance commissioner's, for CLHIGA to impose permanent and temporary policy or contract liens or moratoriums on the payment of cash values or policy loans in connection with a guarantee, assumption, or reinsurance agreement.

It extends this authority to any other right to withdraw policy or contract funds and specifies that the authority is in addition to any contractual provisions for the deferral of cash or policy loan values. It authorizes CLHIGA to defer the payment of cash values, policy loans or other rights when the receivership court imposes a temporary (a) moratorium charge on of the impaired or insolvent insurer's assets, or (b) moratorium on the payment of cash values, policy loans, or other withdrawal rights. The deferment is for the period of the moratorium or moratorium charge. The bill exempts claims paid by CLHIGA in accordance with the liquidator or rehabilitator's hardship procedure and approved by the receivership court.

In order to impose a permanent lien, CLHIGA must find that the amount it assesses member insurers in connection with a guarantee, assumption, or reinsurance agreement (1) is less than needed to discharge its obligations or (2) that the economic or financial conditions are sufficiently adverse to require imposing a permanent policy or contract lien in the public interest.

Intervention In Proceedings

The bill extends CLHIGA's authority to intervene in state court proceedings to the proceedings of state agencies with jurisdiction over an impaired or insolvent insurer or any person or property against which CLHIGA may have subrogation rights. By law, CLHIGA has

state court standing in insolvency proceedings. The bill also extends CLHIGA's standing and intervention rights to court and agency proceedings in other states with jurisdiction over an impaired or insolvent insurer or any person or property against which the CLHIGA may have rights or for which CLHIGA is or may become obligated.

Assignment of Rights

The bill broadens CLHIGA's authority to require people receiving benefits from substitute or alternative coverage to assign their rights to CLHIGA, to the extent of such benefits under the policy or contract. Under current law, CLHIGA can require assignment for payment of contractual obligations or the continuation of coverage. The bill extends CLHIGA's right of assignment to causes of action against people for losses arising under, resulting from, or relating to covered policies or contracts. Under the bill, payees, policy or contract owners, beneficiaries, insureds, or annuitants can also be required to assign their rights or causes of action as a precondition to receiving benefits.

Subrogation

The bill broadens CLHIGA's right of subrogation to include those rights acquired by succession and under common law, and it adds authority for CLHIGA to pursue other equitable or legal rights that would have been available to the impaired or insolvent insurer or any owner, beneficiary, or payee of a policy or contract against a person responsible for losses from personal injury. The right of subrogation includes the pursuit of any owner, beneficiary or payee's right under a structured settlement annuity. The bill exempts anyone responsible for injury while serving as an assignee under a qualified Internal Revenue Service assignment from CLHIGA's right of subrogation. By law, CLHIGA's right of subrogation against the assets of an impaired insurer applies to any person receiving CLHIGA benefits.

The bill specifies that if CLHIGA's rights of assignment, including causes of action or subrogation, are held invalid or ineffective against any person or claim, CLHIGA is entitled to reduce the amount it pays (set off) by the amount realized by such person with respect to any covered person or claim. It also specifies that CLHIGA is entitled to

reimbursement of a portion of any recovery attributable to covered policies if it provided benefits to cover an obligation and a person recovers amounts to which CLHIGA has rights.

REINSURANCE ARRANGEMENT

The bill allows CLHIGA to succeed to the rights of an impaired or insolvent insurer under a reinsurance agreement if it elects to do so within one year after the date it became obligated to cover an impaired or insolvent insurer's policies or contracts (known as the coverage date). On or after the coverage date, the election permits CLHIGA to succeed to the rights and obligations of the impaired or insolvent insurer under any indemnity reinsurance agreement it entered into as a ceding insurer. The bill prohibits CLHIGA from exercising the election if the impaired or insolvent insurer's receiver, rehabilitator, or liquidator disaffirmed the reinsurance agreement. The election must be exercised by notice to the receiver, rehabilitator, or liquidator, and reinsurer. If CLHIGA succeeds to such rights and obligations it:

1. must be responsible for all unpaid premiums due under the reinsurance agreement before and after the coverage date and perform all other obligations related to any covered contract after the coverage date, including charging each covered contract or policy the reinsurance costs in excess of CLHIGA's obligation;

2. is entitled to amounts paid by the reinsurer under the agreement for losses or events that happened after the coverage date and must pay any beneficiary of a policy or contract in which CLHIGA only paid a portion of the amount due the amount it received that exceeds the benefits paid the beneficiary under the policy or contract, less any amount retained by the impaired or insolvent insurer applicable to the loss or event;

3. must calculate, within 30 days after CLHIGA's election, along with each indemnity reinsurer, the net balance due to or from CLHIGA under each agreement as of the date of its election, giving full credit to the amounts paid by the insurer or its receiver, rehabilitator, liquidator, or the indemnity reinsurer during the period between the coverage date and the date of CLHIGA's election. CLHIGA or the indemnity reinsurer must pay the net balance within five days

after completing the calculation. If the receiver, rehabilitator, or liquidator received any amounts due CLHIGA they must promptly remit it to CLHIGA.

The bill specifies that if CLHIGA pays the premium within 60 days after its election for the periods before and after the coverage date, the reinsurer is not entitled to terminate the reinsurance agreement or any set off against amounts due CLHIGA for any unpaid premium due for the periods before the coverage date.

The bill permits CLHIGA to transfer its obligations to another insurer, and if it and the other insurer agree, the other insurer then succeeds to the rights and obligations of CLHIGA under the reinsurance agreement. If this occurs, (1) the indemnity reinsurance agreement is automatically terminated for new reinsurance unless otherwise agreed to between the indemnity reinsurer and the other insurer and (2) CLHIGA's obligation to pay the beneficiary no longer applies on or after the date the indemnity reinsurance agreement is transferred.

The bill specifies that the reinsurance provisions supersede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds to the receiver, rehabilitator, or liquidator on account of losses or events that occur after the coverage date. The receiver, rehabilitator, or liquidator remain entitled to amounts paid by the reinsurer under the reinsurance agreement for losses or events that occur before the coverage date, subject to any set off.

The bill prohibits alteration or modification of the terms and conditions of the insolvent insurer's indemnity reinsurance agreement unless expressly allowed in the bill. It also prohibits abrogating or limiting the reinsurer's right to rescind a reinsurance agreement and specifies that it doers not give a policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise stated in the agreement.

ADDITIONAL ASSOCIATION POWERS AND VENUE

The bill authorizes CLHIGA to (1) request information from people seeking coverage from it in order to help CLHIGA determine its

obligation and requires such persons to promptly comply with such requests, (2) take necessary or proper action and exercise its powers to discharge its duties and obligations, and (3) join an organization of one or more other state associations to further the purposes and administer CLHIGA's powers and duties.

Finally, the bill specifies that lawsuits against CLHIGA must be brought in the Hartford Superior Court and that CLHIGA is not required to post an appeal bond in appeals that relate to a cause of action under the bill.

ASSOCIATION ASSESSMENTS

CLHIGA imposes assessments on its member insurers to raise funds to fulfill its statutory obligations. The assessments are based on the amount of premiums members write in the state. The bill modifies CLHIGA's assessment accounts. It includes annuity contracts owned by government retirement plans in the annuity sub-account and eliminates it from the unallocated annuity sub-account.

The bill makes a number of changes relating to assessments. It:

1. requires CLHIGA members to pay late payment interest of one percent per month, or any part thereof, on assessments and calculates interest from the due date to the date of payment;

2. reduces the classes of assessments from three to two to reflect the elimination of the distinction between an impaired foreign or alien insurer and an impaired domestic insurer;

3. limits class "A" assessments (for administrative costs and general expenses) to $150 per member in any one calendar year when made on a non-pro-rata basis;

4. allocates class "B" assessments (used to fund the CLHIGA's obligations under the Act) according to a formula based on the premiums or reserves of the impaired or insolvent insurer or on standards the CLHIGA's board deems fair and reasonable;

5. allows class "B" assessments to be based on the most recent three

calendar years of information preceding the year in which an insurer became insolvent or impaired; rather than one;

6. requires members to pay all deferred assessments under a repayment plan CLHIGA approves once the financial difficulty causing the deferral has been rectified;

7. limits the total of all authorized assessments for each sub-account (life and annuity) and for the health insurance account to two percent of the insurer's average annual premium received in Connecticut on policies covered by the accounts during the three calendar years preceding the year in which the insurer became impaired or insolvent;

8. limits the aggregate assessment percentage to an amount equal and limited to the higher of the three-year average annual premium of the applicable sub-account or account when two or more assessments are authorized in one calendar year;

9. adds assets derived from assignment and subrogation in determining excess assets of any account for purposes of a refund;

10. requires CLHIGA to notify members within 180 days after it authorizes an assessment of its pro-rata share of an authorized assessment that has not yet been called; and

11. allows CLHIGA to make pro-rata assessments, instead of non-pro-rata assessments only.

The bill specifies that when pro-rata assessments are made CLHIGA's board may credit it against future class "B" assessments, and it extends assessment requirements to insurer insolvencies.

The bill defines an "authorized assessment" as one passed by resolution of CLHIGA's board to be called immediately or in the future from member insurers for a specified account. A "called assessment" is one where a notice has been issued by CLHIGA to member insurers requiring an authorized assessment to be paid within the time specified in the notice.

Assessment Protest

The bill gives member insurers the right to protest an assessment. The insurer must pay the assessment when due as set forth in the notice. The bill specifies that payment must be available for CLHIGA to meet its obligations during the time a protest is pending and any subsequent appeal. It requires a written statement that payment is made under protest, and the grounds for the protest must accompany the payment. Within 60 days following payment under protest, CLHIGA must notify the member in writing of its decision about the protest. CLHIGA also must notify the member if it needs additional time. Within 30 days after making a final decision CLHIGA must notify the protesting member about it. Within 60 days after receiving the notice of final decision, the protesting member may appeal to the insurance commissioner. If the protest was based on a question about the assessment base, CLHIGA may refer the protest to the commissioner with a recommendation, instead of rendering a final decision. If the protest or appeal is upheld, the amount or excess paid in must be returned to the member insurer. CLHIGA must pay interest at the rate it actually earned on a refund due a protesting member.

The bill specifies that CLHIGA may request information from member insurers to help it set assessments, and members must promptly comply with the request.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 18 Nay 0